TRACKING NUMBER

Please return form to: **PROVIDER APPEALS, PO BOX 378021, DENVER, CO 80237- 9998**

PROVIDER DISPUTE MULTIPLE CLAIMS RESOLUTION REQUEST

NOTE: WE STRONGLY URGE NON-CONTRACTED PROVIDERS NOT TO BILL HEALTH PLAN MEMBERS DURING THE DISPUTE RESOLUTION PROCESS.

PROVIDER NAME

PROVIDER TAX ID

PROVIDER TYPE
(CHECK ALL THAT APPLY)

Contracted   Professional Provider

Non-Contracted   Institutional Provider

Other Provider (please specify):

Please provide detailed information as to how the following claims should have been processed

Description given here must apply to all claims listed below. If additional space is needed, please use a separate sheet and attach it to this form.
Required attachments: Copy of Original Claim and Remittance notification showing the denial

Patient Name	Patient Date of Birth	Medical Record #	Kaiser Claim #	Date Of Service	Billed Amount	Paid Amount

Contact Name (Please Print)   Title

Signature   Phone Number   Date

NOTE: Please attach any support for your dispute, which may include additional supporting documentation, medical documentation (if appropriate), any related laws/regulations you believe are relevant, or any other information you believe would be helpful.

Please return form to: **KP HAWAII – PROVIDER APPEALS, CLAIMS ADMIN DEPT, PO BOX 378021, DENVER, CO 80237-9998**